MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04387

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY: A. A Co. MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Md COUNTY: Alt.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Brooklyn Park — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Brooklyn Park
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 216 Audrey Ave.	STREET ADDRESS (If rural, give location): 216 Audrey Ave

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): William Barrett

4. DATE OF DEATH (Month) (Day) (Year): 4 / 26 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Male	White	Widower	Mar 14, 1862	87 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	—	Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas Barrett	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
Unk.	—	—	William M. Barrett

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic myocarditis and myocardial degeneration	2 yrs.
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Senility.	"
	(c)	

422.2

93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1945, to May, 1948, that I last saw the deceased alive on May 5, 1949, and that death occurred at 6 45 a. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
P. J. Grimaldi	4609 Gov. Ritchie Hwy	Balto Md	5-27-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5/28/49	Mt Olivet Cem.	Frederick Ave

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
May 28th 1949	R.W. [illegible]	John Thienny Inc	715 Light St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

014388

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 311 Washington St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
STREET ADDRESS (If rural, give location) 311 Washington St

3. NAME OF DECEASED (Type or Print): (First) Emma (Middle) B. (Last) Bast
4. DATE OF DEATH: (Month) 5 (Day) 20 (Year) 1949
5. SEX F
6. COLOR OR RACE W.
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH 7-5-1866
9. AGE last birthday 82 yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (State or foreign country) Annapolis Md
12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME William Holidayoke
14. MOTHER'S MAIDEN NAME Sarah J. Hooker
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs Walter L. Bennett Jr.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Myocarditis — Interval Between Onset and Death: 2 years.

Antecedent cause(s) (b) Arteriosclerosis — Several years.

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

422.1 93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ~~Feb~~, 1949, to May 20, 1949, that I last saw the deceased alive on May 20, 1949, and that death occurred at 6 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
George C. Basil M.D. Annapolis Md 5.21.49

23. BURIAL, ~~CREMATION~~, REMOVAL (Specify) | DATE 5-22-49 | NAME OF CEMETERY OR CREMATORY Cedar Bluff | LOCATION (City, town, or county) (State) Annapolis Md.

DATE REC'D BY LOCAL REG. May 22, 1949 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR John M. Taylor Son | ADDRESS Annapolis Md.

RECEIVED
MAY 24 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04389

CERTIFICATE OF DEATH

Reg. Dist. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ft Meade, Maryland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Ft Meade, Station Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ft George G Meade, Maryland
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) Alma (Middle) F (Last) Beach

4. DATE OF DEATH: (Month) May (Day) 28 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 12 Nov 1890

9. AGE last birthday: 58 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cleveland, Ohio

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Victor Voss

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 292-12-1288

17. INFORMANT: Major William Beach -Son of Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Respiratory Failure	5 Hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinomatosis, primary site unknown	
	(c)	

199.8
55 c

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION: None

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 18 May, 1949, to 28 May, 1949, that I last saw the deceased alive on 28 May, 1949, and that death occurred at 4:45 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Harold R. Griffith — ADDRESS: HAROLD R. GRIFFITH CAPTAIN MEDICAL CORPS, Ft Meade, Maryland — DATE SIGNED: 28 May 1949

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF: 28 May 1949

NAME OF CEMETERY OR CREMATORY: Unknown

LOCATION (City, town, or county) (State): Cleveland, Ohio

DATE REC'D BY LOCAL REG.: 31 May 1949

REGISTRAR'S SIGNATURE: E.K. Burnside

E.K. BURNSIDE, Capt., MSC

24. FUNERAL DIRECTOR: DeWitt Donaldson — ADDRESS: Laurel Maryland

RECEIVED
JUN 1 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04390

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH
COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Fort George G Meade, Md
LENGTH OF STAY (In this place): --
HOSPITAL OR INSTITUTION OR STREET ADDRESS: STATION HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: District of Columbia — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN:
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) FRED (Middle) J (Last) BEUCHERT

4. DATE OF DEATH: (Month) MAY (Day) 4 (Year) 1949

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M

8. DATE OF BIRTH: 13 April 1920

9. AGE last birthday: 29 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier

10b. KIND OF BUSINESS OR INDUSTRY: US Army

11. BIRTHPLACE (State or foreign country): District of Columbia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): W.W. II.

16. SOCIAL SECURITY No.:

17. INFORMANT: Service Records US Army

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Wound, perforating, gunshot, temple, left

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

INTERVAL BETWEEN ONSET AND DEATH:

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes X No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): Suicide
PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: Firing Range
(CITY OR TOWN): Fort Geo G Meade
(COUNTY): Anne Arundel
(STATE): Md

TIME OF INJURY (Month) (Day) (Year) (Hour): May 4 49 1100n.
INJURY OCCURRED While at Work X Not While At work ☐
HOW DID INJURY OCCUR? Self inflicted

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased dead on arrival alive on 4 May, 19 49, and that death occurred at instantly m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
David R. Metcalf
David R Metcalf Capt., M.C. — Fort George G Meade, Md — 6 May 1949

23. BURIAL, CREMATION REMOVAL (Specify): Removal
DATE THEREOF: 4 May 1949
NAME OF CEMETERY OR CREMATORY: Arlington National
LOCATION (City, town, or county) (State): Arlington, Virginia

DATE REC'D BY LOCAL REG.: 5 May 1949
REGISTRAR'S SIGNATURE: E. K. BURNSIDE, Capt., MSC
24. FUNERAL DIRECTOR: Lily & Zeiler, Inc
ADDRESS: Baltimore Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 9 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04391

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville | LENGTH OF STAY in this place) 11 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Mayland — COUNTY Pr. Geo.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bladensburg
STREET ADDRESS (If rural, give location) 4108 46th Street

3. NAME OF DECEASED (Type or Print): (First) Madison (Middle) J. (Last) Brown
4. DATE OF DEATH: (Month) 5/15/49 (Day) (Year) 19

5. SEX: male
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: ~~(Month) (Day) (Year)~~ not known 1862
9. AGE last birthday: 87 (?) yrs. | If under 1 year: Months. Days | If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): not known
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: R. B. Brown
14. MOTHER'S MAIDEN NAME: Marth Forbes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Hemorrhage	known for twenty minutes
Antecedent cause(s)	(b)	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Cerebral Arteriosclerosis	known since admission

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour)
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/22/38, 19....., to 5/15/49, 19....., that I last saw the deceased alive on 1:10 P.M., 5/15/49, 19....., and that death occurred at 1:10 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Jacob Mayerstein M.D. Crownsville, Maryland 5/15/49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE 20 May | NAME OF CEMETERY OR CREMATORY Methodist Cemetery | LOCATION (City, town, or county) (State) Bladensburg Md.

DATE RECD BY LOCAL REG. 5/19/49 | REGISTRAR'S SIGNATURE E.T. Joyce Local Reg. | 24. FUNERAL DIRECTOR ADDRESS J. Baird Sons, - Hyatts, Md.

RECEIVED
MAY 19 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 24

04392

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (In this place) 2 mos. 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Balt. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Philmore (Middle) (Last) Brown

4. DATE OF DEATH: (Month) 5/18/49 (Day) (Year) 19

5. SEX: male

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: April 19, 1881

9. AGE last birthday: 68 yrs. If under 1 year (Months, Days, Hours) If under 24 hrs. (Hours, Min.)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Philmore Brown

14. MOTHER'S MAIDEN NAME: Jane Richardson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) General Arteriosclerosis — Interval between onset and death: known to us since 3/14/49

450.0

Antecedent cause(s)

97

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/14/49, 19....., to 5/18/49, 19....., that I last saw the deceased alive on 5:20 A./ 5/18/49, 19....., and that death occurred at 5:20 A. m., from the causes and on the date stated above.

SIGNATURE Jacob Mordecai M.D. (Degree or title) ADDRESS Crownsville, Maryland DATE SIGNED 5/18/49

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE 5-20-49 | NAME OF CEMETERY OR CREMATORY Mt. Auburn | LOCATION (City, town, or county) (State) Baltimore ~~County~~ Md.

DATE REC'D BY LOCAL REG. 5/18-49 | REGISTRAR'S SIGNATURE E. Joyce Logan Reg | 24. FUNERAL DIRECTOR Mr Samuel T. Hensley ADDRESS 578 W. Biddle Street

RECEIVED
MAY 20 1949
BUREAU Y. S.

04393

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 16 Cornhill St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 61 Cornhill St.

3. NAME OF DECEASED (Type or Print): (First) Marguerite (Middle) D. (Last) Burner
4. DATE OF DEATH: (Month) May (Day) 26 (Year) 1949

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 11, 1905
9. AGE last birthday: 43 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Sauers
14. MOTHER'S MAIDEN NAME: Margaret Sachse

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: 16 Cornhill St., Annapolis Mr. Howard E. Burner

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinoma, left breast, with metastases — 18 mos.

170 Antecedent cause(s)

30 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary tuberculosis, active, bilateral — 4 yrs.

19a. DATE OF OPERATION: 1948
19b. MAJOR FINDINGS OF OPERATION: Carcinoma left breast
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 3, 1948, to May 26, 1949, that I last saw the deceased alive on May 26, 1949, and that death occurred at 1.50 A.m., from the causes and on the date stated above.

SIGNATURE: Donald H. Hunter (Degree or title) M.D. ADDRESS: 53 Cornhill St. Annapolis, Md. DATE SIGNED: 26 May 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: 5/28/49
NAME OF CEMETERY OR CREMATORY: Woodlawn Cem.
LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE REC'D BY LOCAL REG.: 5/27/49
REGISTRAR'S SIGNATURE: D. W. Hedrick
24. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto, Md.

DM

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04394 21 ?

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Patapsico Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:
125 Bishop Ave.

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: Patapsico Park
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 125 Bishop Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME: PRISCILLA BUTLER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 29, 1885

8. AGE:

Years	Months	Days	If less than one day
64	1	18	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER

12. Name: Thomas Robinson

13. Birthplace: Md.

MOTHER

14. Maiden name .....

15. Birthplace: Md.

16. Informant: Mrs. Doretha Chester

Address: 125 Bishop Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5-21-49 (month) (day) (year)

Cemetery or crematory: Mt. Auburn Com.

Location: Baltimore, Md.

18. Funeral director: Mrs. Frances A. Hemsley

Address: 578 W. Biddle St.

19. 5/19/49 (Date rec'd by registrar) 19..... A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17 1949, at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 2-19 1949, to 4-23 1949, and that I last saw h.E.R. alive on April 23, 1949

Immediate cause of death	DURATION
Myocardial Failure	?
Due to: Hypertensive Cardio-vascular Disease	?
Due to: 443 934	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Thomas W. Harris M.D.
M. D. or other

Address: 1824 W. Franklin St. Date signed: 5-17-49

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04395

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parole — LENGTH OF STAY (in this place) Life	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parole, Md. near Annapolis
HOSPITAL OR INSTITUTION OR STREET ADDRESS Parole, Md. near Annapolis	STREET ADDRESS (If rural give location) Parole, Md. near Annapolis

3. NAME OF DECEASED (Type or Print) (First) Clinton	(Middle)	(Last) Carter	4. DATE OF DEATH (Month) 5-	(Day) 30	(Year) - 49
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 7/ 26/ 1902	9. AGE last birthday 46 yrs.	If under 1 year Months Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Parole, Md. near Annapolis	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Charles Carter		14. MOTHER'S MAIDEN NAME Mary Lane			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes	(If year, give war or dates of service) 1918-1919	16. SOCIAL SECURITY NO. 220-07-48622	17. INFORMANT Mary Carter Herndon		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinoma of Stomach — 1 Year

151 Antecedent cause(s) (h) —

46b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —	19b. MAJOR FINDINGS OF OPERATION —	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 15, 1949, to May 30, 1949, that I last saw the deceased alive on May 30, 1949, and that death occurred at 5:00 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
R. F. Richardson	MD	110 - Clay St. Annapolis, Md	6/1/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 6- 2- 1949	NAME OF CEMETERY OR CREMATORY Brewer Hill Cemetery	LOCATION (City, town, or county) (State) West St. Annapolis, Md.
DATE REC'D BY LOCAL REG. June 1, 1949	REGISTRAR'S SIGNATURE [signature]	24. FUNERAL DIRECTOR Mrs. Charles E. Hicks & Son	ADDRESS 43-45 Northwest St. Annapolis, Maryland

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
JUN 2 1949
BUREAU V. S.

Evidence for change of age is on:

FILM No. G 120 JUN -6 1949

MARYLAND STATE DEPARTMENT OF HEALTH

Bc

04396

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH · COUNTY: Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Balti. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): 1 month 2 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): 107 W. Hill Street

3. NAME OF DECEASED (Type or Print)	(First) Wilmer	(Middle) Roosevelt	(Last) Conway	4. DATE OF DEATH	(Month) 5/23/49 (Day) (Year) 19
5. SEX: male	6. COLOR OR RACE: colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): separated	8. DATE OF BIRTH: 6/16/08	9. AGE last birthday: ~~41~~ 40 yrs.	If under 1 year Months Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer	10b. KIND OF BUSINESS OR INDUSTRY: none	11. BIRTHPLACE (State or foreign country): Delaware	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME: Icke Hollaway	14. MOTHER'S MAIDEN NAME: not known				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: Hospital Records			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) General Paresis	known
Antecedent cause(s)		since
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	admission
	(c)	

025

30 b

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/21/49, 19....., to 5/23/49, 19....., that I last saw the deceased alive on 5/23/49, 19....., and that death occurred at 9?20 A.M. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Morgenstern M.D.		Crownsville, Maryland	5/23/49

23. BURIAL CREMATION REMOVAL (Specify)	DATE 5/26/49	NAME OF CEMETERY OR CREMATORY: Odd Fellows Cem	LOCATION (City, town, or county) (State): Wellsburg Md
DATE REC'D BY LOCAL REG. May 24, 1949	REGISTRAR'S SIGNATURE: Wm. J. Frenck	24. FUNERAL DIRECTOR: Boyer T.H. - Salisbury, Md.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
MAY 31 1949
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04397

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Md. Linthicum MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum
LENGTH OF STAY (in this place) 2 1/2 yr.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 409 W. Maple Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY An. Ar.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum
STREET ADDRESS (If rural, give location) 409 W. Maple Rd.

3. NAME OF DECEASED (Type or Print) (First) Wm (Middle) (Last) Dachnke

4. DATE OF DEATH (Month) May (Day) 15 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Jan 19-1865
9. AGE last birthday 84 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME Wm Dachnke
14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Gaylor Watts

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cardio-Vascular Disease	3 yr.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterio-Sclerosis	10 yr.
	(c)	

422.1
93d

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Oedema Legs & Lungs.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb., 1947, to May 15, 1949, that I last saw the deceased alive on May 15, 1949, and that death occurred at 2:30 P m., from the causes and on the date stated above.

SIGNATURE Chas. L. Ball (Degree or title) Jr MD. ADDRESS Linthicum DATE SIGNED 5/15/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 5-17-49
NAME OF CEMETERY OR CREMATORY Western Cem
LOCATION (City, town, or county) (State) Edmondson Ave.

DATE REC'D BY LOCAL REG. 5/16/49
REGISTRAR'S SIGNATURE L. J. DeAlba
24. FUNERAL DIRECTOR Edward Foulson ADDRESS 2357 Wash. Blvd

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MAY 17 1949
BUREAU V. S.

04398

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 23

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ferndale
LENGTH OF STAY (in this place) few hrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS in cell block at Police Headquarters County Police

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Marley Park
STREET ADDRESS (If rural, give location) Holloway Road

3. NAME OF DECEASED (Type or Print) (First) Bessie (Middle) May (Last) Elberts
4. DATE OF DEATH (Month) May (Day) 7 (Year) 1949
5. SEX female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Divorced
8. DATE OF BIRTH Feb 7, 1906
9. AGE last birthday 43 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seemstress
10b. KIND OF BUSINESS OR INDUSTRY Stein Uniform Co.
11. BIRTHPLACE (State or foreign country) Marion Sta. Dorchester Co. Md
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME Littleton Tatman
14. MOTHER'S MAIDEN NAME Bertha May Bonneville
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes. (If yes, give war or dates of service) Wack. W.W.2
16. SOCIAL SECURITY NO. 213-05-0201
17. INFORMANT Mrs. Catherine Wheeler, Marley Park, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Suicide.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hanging by neck.

(c)

INTERVAL BETWEEN ONSET AND DEATH

974
1640

II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffy, M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis, Md DATE SIGNED 5-7-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF May 10, 1949
NAME OF CEMETERY OR CREMATORY Glen Haven
LOCATION (City, town, or county) Glen Burnie (State) Md.

DATE REC'D BY LOCAL REG. 5/8/49
REGISTRAR'S SIGNATURE L. J. D. Albo
24. FUNERAL DIRECTOR Thomas W. Swighton ADDRESS Glen Burnie, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

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MAY 10 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04399

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ANNE ARUNDEL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. NAVAL HOSPITAL	STREET ADDRESS UNKNOWN (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Morris Jr (Last) FIELD

4. DATE OF DEATH: (Month) MAY (Day) 30 (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: WHITE -US

7. ~~SINGLE, MARRIED, WIDOWED~~ DIVORCED, (Specify)

8. DATE OF BIRTH: 27 March 1893

9. AGE last birthday: 56 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: RETIRED USN

11. BIRTHPLACE (State or foreign country): District of Columbia

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: John Morris FIELD SR.

14. MOTHER'S MAIDEN NAME: Carolina WELLS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Hypostatic pneumonia.	6 days
199.1 Antecedent cause(s)	(b) Carcinoma, neck.	1 year
55e Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Extension of carcinoma to lungs and cranial vault.	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 1948

19b. MAJOR FINDINGS OF OPERATION: Radical dissection neck done at Memorial Hosp., New York.

20. AUTOPSY? Yes X No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 29 March, 1949, to 30 May, 1949, that I last saw the deceased alive on 30 May, 1949, and that death occurred at 12:10 p.m., from the causes and on the date stated above.

SIGNATURE E.P. Harris (Degree or title) ADDRESS DATE SIGNED

30 May 1949 E.P. HARRIS CDR, MC USN U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.

23. BURIAL, CREMATION REMOVAL (Specify) — DATE 5/31 — NAME OF CEMETERY OR CREMATORY Cedar Hill Crem — LOCATION (City, town, or county) Suitland Md (State)

DATE REC'D BY LOCAL REG. May 30, 1949 — REGISTRAR'S SIGNATURE [signature] — 24. FUNERAL DIRECTOR Jas Fowler & Sons — ADDRESS 1756 Palm. Wash. DC

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 1 1949
BUREAU V. S.

Evidence for change of age is on:

FILM No. G 120 MAY 16 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04400

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH — COUNTY: A. A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Linthicum
LENGTH OF STAY (in this place): 1 yr.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 42 Patapsco Ave

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: MARYLAND — COUNTY: ANNE ARUNDEL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: North Linthicum (Linthicum Hghts. P.O. Md)
STREET ADDRESS (If rural, give location): 42 Patapsco Road

3. NAME OF DECEASED (Type or Print): (First) Ida (Middle) Lee (Last) Fooks
4. DATE OF DEATH: (Month) May (Day) 8 (Year) 1949

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow
8. DATE OF BIRTH: Oct. 31 1867
9. AGE last birthday: ~~8~~ 81 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Church Creek Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: L. Fitzhugh
14. MOTHER'S MAIDEN NAME: Sarah Linthicum

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Eva M. Fooks.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cardio-Vascular Disease	1 yr.
434.2 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cardiac Asthma	20 yrs
93d	(c)	

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov., 1948, to May 8, 1949, that I last saw the deceased alive on May 8, 1949, and that death occurred at 10:25 A.m., from the causes and on the date stated above.

SIGNATURE: Chas. L. Ball Jr (Degree or title) MD — ADDRESS: Linthicum Md — DATE SIGNED: May 8 - 1949

23. BURIAL, CREMATION REMOVAL (Specify): BURIAL — DATE THEREOF: May 10 1949 — NAME OF CEMETERY OR CREMATORY: OLD TRINITY CEMETERY — LOCATION (City, town, or county) (State): Church Creek Md

DATE REC'D BY LOCAL REG.: 5/8/49 — REGISTRAR'S SIGNATURE: L. J. De Alba — 24. FUNERAL DIRECTOR: Thomas W. Singleton, Glen Burnie Md. — ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 10 1949
BUREAU V. S.

04401

MARYLAND STATE DEPARTMENT OF HEALTH BC

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel County MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY ~~Baltimore C.~~
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville — LENGTH OF STAY (in this place) 1 yr. 5 mos.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital	STREET ADDRESS (If rural, give location) 15 Mosher Street ✓

3. NAME OF DECEASED (Type or Print) (First) Leatrice (Middle) (Last) Grant			4. DATE OF DEATH (Month) 5/11/49 (Day) (Year) 19		
5. SEX Female	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH 1885	9. AGE last birthday 64 yrs.	If under 1 year Months Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) not known	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) not known	12. CITIZEN OF WHAT COUNTRY? *****		
13. FATHER'S NAME not known		14. MOTHER'S MAIDEN NAME not known			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) *** (If year, give war or dates of service)	16. SOCIAL SECURITY No. **********	17. INFORMANT Hospital Records			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) General Paresis	known since
Antecedent cause(s)		1/27/48
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

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II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION **********	19b. MAJOR FINDINGS OF OPERATION **********	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify) **********	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ********** (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) ********** m.	INJURY OCCURRED While at Work ☐ Not While At work ☐ **********	HOW DID INJURY OCCUR? **********

22. I hereby certify that I attended the deceased from 1/9/48, 19....., to 5/11/49, 19....., that I last saw the deceased alive on 5/11/49, 19....., and that death occurred at 2:00 P.M. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Morgenstern M.D.		Crownsville, Maryland	5/11/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 5/14/49	NAME OF CEMETERY OR CREMATORY Hospital	LOCATION (City, town, or county) (State) Crownsville Md
DATE REC'D BY LOCAL REG. 5/14/49	REGISTRAR'S SIGNATURE E. F. Joyce L. Reg.	24. FUNERAL DIRECTOR Ruph. Hospital	ADDRESS Crownsville Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
MAY 16 1949
BUREAU V. S.

Dr. Richardson

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04402

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Shadyside
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Shadyside
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Rachel (Middle) Gray (Last)

4. DATE OF DEATH (Month) May (Day) 18 (Year) 1949

5. SEX Female

6. COLOR OR RACE Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH 1878

9. AGE last birthday 71 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Churchton, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT George Thompson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Broncho-Pneumonia — 8 days

422.2 Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) Chronic Myo Carditis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 1st, 1949, to May 18, 1949, that I last saw the deceased alive on May 18th, 1949, and that death occurred at 1:00 p.m., from the causes and on the date stated above.

SIGNATURE R. L. Richardson M.D. (Degree or title) ADDRESS Annapolis, Md. DATE SIGNED 5/20/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE May 21, 1949

NAME OF CEMETERY OR CREMATORY Franklin

LOCATION (City, town, or county) Shadyside, Md. (State)

DATE REC'D BY LOCAL REG. ~~May 21, 1949~~ May-24 1949

REGISTRAR'S SIGNATURE T. B. Dent

24. FUNERAL DIRECTOR J. B. Johnson, Annapolis, Md. ADDRESS

RECEIVED
MAY 26 1949
BUREAU V. S.

Dr Lindert

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04403

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis, LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hosptial	STREET ADDRESS (If rural give location) 911 Madison St.

3. NAME OF DECEASED (Type or Print) (First) Thomas (Middle) Edward (Last) Grierson			4. DATE OF DEATH (Month) May (Day) 10, (Year) 1949		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH May 9, 1883	9. AGE last birthday 66 yrs.	If under 1 year Months 0 Days 1 If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Frederick Grierson			14. MOTHER'S MAIDEN NAME Mayr R. Cochrane		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN (If yes, give war or dates of service)	16. SOCIAL SECURITY No. 214-05-1944		17. INFORMANT Mr Henry Grierson		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Hypertensive Cardiovascular disease — 10 yrs.

443

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

93d

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1939, 19....., to May 10, 1949, that I last saw the deceased alive on May 10, 1949, and that death occurred at ✓ m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
E Kim Hart	MD	Eastport Maryland	May 11-1949.

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF May 13, 1949	NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery	LOCATION (City, town, or county) (State) Glen Burnie, Maryland
DATE REC'D BY LOCAL REG. May 12, 1949	REGISTRAR'S SIGNATURE [signature]	24. FUNERAL DIRECTOR Ben L. Hopping and Son	ADDRESS Annapolis, Marylan

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

RECEIVED
MAY 13 1949
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04404

Reg. Dist. No. 25

1. PLACE OF DEATH: A A Co

County

City or town: Bklyn Hgts.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State: Md. County:

City or town: Bklyn Hgts.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 409 Townsend Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: William S. Griffiths

3. (b) Social Security Number

4. Sex: M.

5. Color or race: W

6.(a) Single, married, widowed, or divorced: W.

6.(b) Name of husband or wife: Callie

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 9-23-1886

8. AGE: Years: 62 Months: 7 Days: 14 If less than one day ..... hrs. ..... min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: None.

11. Industry or business

FATHER

12. Name: George Griffiths

13. Birthplace: England

MOTHER

14. Maiden name: Mary Jenks

15. Birthplace: England.

16. Informant: Family

Address: Same.

17. B. (Burial, cremation, or removal. Which?) Date thereof: 5-9-49 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Brooklyn.

18. Funeral director: James L. McCully

Address: 130 E. Fort Ave.

19. May 9 1949 (Date rec'd by registrar) Ida M. Hutson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5/7/49 19..... at 3:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 1948, to June 7 1949 and that I last saw ~~h~~ alive on 4/28 1949

Immediate cause of death: ~~[illegible]~~ carcinoma of stomach

Due to

Due to: arthritis

Other conditions: 151 46b (Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Samuel Rush M. D. or other

Address: 203 Patterson Date signed

RECEIVED
MAY 21 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

04405

Reg. Dist. No. 26

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Nutwell
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md Nutwell COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Nutwell
STREET ADDRESS (If rural, give location) Franklin's Farm

3. NAME OF DECEASED (Type or Print) (First) Thomas (Middle) Henry (Last) Gross
4. DATE OF DEATH (Month) May (Day) 26 (Year) 1949

5. SEX Male
6. COLOR OR RACE Cd
7. ~~SINGLE, MARRIED,~~ WIDOWED, ~~DIVORCED,~~ (Specify)
8. DATE OF BIRTH May 16, 1884
9. AGE last birthday 65 yrs. | If under 1 year Months | Days | If under 24 hrs. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME Plummer Gross
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Henry W. Gross

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute Dilatation of Heart	sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Myocarditis	unknown
	(c) Cardio-vascular Disease	unknown

422.1
93d

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Caffey M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis, Md DATE SIGNED 5-26-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF May 29, 1949
NAME OF CEMETERY OR CREMATORY Friendship Cem
LOCATION (City, town, or county) Friendship A.A.Co (State) Md

DATE REC'D BY LOCAL REG. May 28, 49
REGISTRAR'S SIGNATURE J. B. Dent
24. FUNERAL DIRECTOR T. A. Hardesty & Son ADDRESS Galesville Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

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RECEIVED
JUN 1 1949
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04416

Reg. Dist. No. 25

1. PLACE OF DEATH — COUNTY: ~~Baltimore~~ Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Brooklyn Park
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md. COUNTY: ~~Baltimore~~ Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Brooklyn Park
STREET ADDRESS (If rural, give location): 5414 Wasena Avenue

3. NAME OF DECEASED (Type or Print): (First) LOUIS (Middle) (Last) HAJOVSKY

4. DATE OF DEATH: (Month) May (Day) 6, (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: April 1, 1876

9. AGE last birthday: 73 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Czechoslovakia

12. CITIZEN OF WHAT COUNTRY: U.S.

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Miss Helen Kayval-dght-5414 Wasena Avenue

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardiac failure — 8 hours

420.0

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
1248

(b) Arteriosclerotic heart disease — Many years

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cirrhosis of liver

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-6, 1949, to 5-6-, 19 49, that I last saw the deceased alive on 5-6, 1949, and that death occurred at 7:30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Donald J. Barnett, M.D. Camp Meade & Linthicum Hts. Md. 5-7-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: 5/10/49

NAME OF CEMETERY OR CREMATORY: Holy Cross Cemetery

LOCATION (City, town, or county) (State): Ritchie Highway

DATE REC'D BY LOCAL REG.: 5/9/49

REGISTRAR'S SIGNATURE: A. W. Hedges

24. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc.

ADDRESS: ~~2601-3-5 E. Madison Street~~

VS. A15

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

04407

1. PLACE OF DEATH: COUNTY Crownsville MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville — LENGTH OF STAY (in this place) 16 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Balti. City

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore

STREET ADDRESS (If rural, give location) 18 Hanover Street

3. NAME OF DECEASED (Type or Print): (First) WILLIE (Middle) COLE (Last) HALL

4. DATE OF DEATH: (Month) (Day) (Year) 5/14/49 19

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 1890

9. AGE last birthday: 59 yrs. — If under 1 year: Months. Days — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): not known

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): North Carolin a

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) ****

16. SOCIAL SECURITY NO. ****

17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage — 20 minutes

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) General Paresis — known to us since 2/24/1933

025

30b

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION ****

19b. MAJOR FINDINGS OF OPERATION ****

20. AUTOPSY? ***** Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) ------

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ------ (CITY OR TOWN) (COUNTY) (STATE) ------

TIME OF INJURY (Month) (Day) (Year) (Hour) ------ m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? ------

22. I hereby certify that I attended the deceased from 2/24/1933 **, 1941, to 5/14, 1949, that I last saw the deceased alive on 5/14, 1949, and that death occurred at 5 p. m., from the causes and on the date stated above.

SIGNATURE: Jacob Morgenstern (Degree or title) M.D. — ADDRESS: Crownsville, Maryland — DATE SIGNED: 5/14/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 5-17-49 — NAME OF CEMETERY OR CREMATORY: W.H. Calvary Cem. — LOCATION (City, town, or county): Cedar Hill — (State): Md.

DATE REC'D BY LOCAL REG.: 5/17/49 — REGISTRAR'S SIGNATURE: A.W. Hedrick — 24. FUNERAL DIRECTOR: Mrs Katie R. Williams — ADDRESS: 322 N Schroeder St

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

114108

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
   LENGTH OF STAY (in this place) dead on arrival
   HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
   STREET ADDRESS (If rural, give location) 25 Monument

3. NAME OF DECEASED (Type or Print): (First) William (Middle) (Last) Harris

4. DATE OF DEATH: (Month) May (Day) 16 (Year) 1949

5. SEX: male

6. COLOR OR RACE: negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Mar. 6, 1889

9. AGE last birthday: 60 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waiter

10b. KIND OF BUSINESS OR INDUSTRY: Commissary Dept

11. BIRTHPLACE (State or foreign country): Annapolis Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: John Harris

14. MOTHER'S MAIDEN NAME: Eliza Giles

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): W.W.I

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mary E. Harris

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary occlusion	sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	unknown
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: John M. Caffy (Degree or title) M.D. Deputy Medical Examiner ADDRESS Annapolis, Md. DATE SIGNED 5-16-49

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF May 19 1949 | NAME OF CEMETERY OR CREMATORY Brewer Hill | LOCATION (City, town or county) Annapolis (State) Md

DATE REC'D BY LOCAL REG. May 17, 1949 | REGISTRAR'S SIGNATURE Jno. J. French | 24. FUNERAL DIRECTOR J. B. Johnson ADDRESS Annapolis, Md.

RECEIVED
MAY 18 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

04409

Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cedarhurst — LENGTH OF STAY (in this place) 2 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cedarhurst, Brady Pide
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) James (Middle) Arthur (Last) Hendrix

4. DATE OF DEATH: (Month) May (Day) 14 (Year) 1949

5. SEX: male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Oct. 23, 1882

9. AGE last birthday: 66 yrs. — If under 1 year: Months — If under 1 year: Days — If under 24 hrs.: Hours — If under 24 hrs.: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Worker of accounts

10b. KIND OF BUSINESS OR INDUSTRY: Red Cross

11. BIRTHPLACE (State or foreign country): Matoon, Illinois

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: (unknown) Hendrix

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Charles L. Stoddard.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Bullet wound in head — INTERVAL BETWEEN ONSET AND DEATH: sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

976
164c

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): May 14 1949 3P m. | INJURY OCCURRED While at work ☐ Not while at work ☑ | HOW DID INJURY OCCUR? .32 cal. revolver

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): John M. Claffy M.D., Deputy Medical Examiner — ADDRESS: Annapolis Md. — DATE SIGNED: 5-14-49

23. BURIAL, CREMATION, REMOVAL (Specify): Removal — DATE THEREOF: 5/14/49 — NAME OF CEMETERY OR CREMATORY: Fort Lincoln — LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG.: May-14-49 — REGISTRAR'S SIGNATURE: J. B. Dent

24. FUNERAL DIRECTOR: T A Hardesty & Son — ADDRESS: Gaithersburg Md

RECEIVED
MAY 17 1949
BUREAU V. S.

M

I

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04410

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: A. A.

City or town: Magothy
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: A. A.

City or town: Magothy
(If outside city or town limits, write RURAL and give nearest town)

Street No.: None
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME William Hill

3. (b) Social Security Number

4. Sex: Male

5. Color or race: colored

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Sarah Hill

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): About 1888

8. AGE: Years: 61 | Months: — | Days: — | If less than one day ..... hrs. ..... min.

9. Birthplace: A. A. Co. Md
(Town, county, and state)

10. Usual occupation: Labourer

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Sarah Hill

Address: Magothy. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 17-49 (month) (day) (year)

Cemetery or crematory: Magothy

Location: A A Co Md

18. Funeral director: James A Hayes

Address: 142 W Hill St

19. 5/17 1949 (Date rec'd by registrar) A W Hadwell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14 1949, at 8:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14 1949, to May 14 1949 and that I last saw him alive on May 14 1949

Immediate cause of death: Cardiac Failure — DURATION: 3 days

Due to: Carcinoma Lungs — 3 months

Due to: .....

Other conditions: 163 / 47d (Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: G. Brady Smith, M.D. M. D. or other

Address: Riviera Beach, Md. Date signed: 5/14/49

Evidence for change of mother's name is on: FILM No. G 120 JUN -6 1949

FILM No. G 120 MAY 27 1949

EVIDENCE FOR ADDITION OF FATHER'S NAME IS ON: FILM No. G 120 MAY 26 1949

04411

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) 61 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Annapolis Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 716 Melrose Street, Cedar Park

3. NAME OF DECEASED (Type or Print) (First) Gurley (Middle) H. (Last) Howard

4. DATE OF DEATH (Month) May (Day) 20 (Year) 1949

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH Dec. 15, 1884

9. AGE last birthday 64 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Windsor, North Carolina

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME JOHN T. HINES

14. MOTHER'S MAIDEN NAME ~~Irma Gurley~~ Hines, Nora Holman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT John H. Howard

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Carcinomatosis	6 months
153 Antecedent cause(s)		
46e Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma of Sigmoid Colon	3 yrs.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Mar. 24, 1949

19b. MAJOR FINDINGS OF OPERATION Carcinoma of Sigmoid Colon

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 1, 1948, to May 20, 1949, that I last saw the deceased alive on May 20, 1949, and that death occurred at 6 20 A.m., from the causes and on the date stated above.

SIGNATURE James R. Martin (Degree or title) M.D. ADDRESS Annapolis, Md. DATE SIGNED 5-20-49

23. BURIAL, CREMATION REMOVAL (Specify) Cremal DATE May 23-49 NAME OF CEMETERY OR CREMATORY Glenwood LOCATION (City, town, or county) Washington, D.C. (State)

DATE REC'D BY LOCAL REG. May 20, 1949 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR S. H. Hines, Co. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 24 1949
BUREAU OF S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

114412
Reg. Dist. No. 23

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Colley, Glen Burnie, Md; LENGTH OF STAY (In this place) 85 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie P.O.,
STREET ADDRESS (If rural, give location) Colley Road

3. NAME OF DECEASED (Type or Print): (First) Georgiana (Middle) (Last) Jackson

4. DATE OF DEATH: (Month) May (Day) 18 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widow

8. DATE OF BIRTH: June 22, 1863

9. AGE last birthday: 85 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Colley, Glen Burnie, Md.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: William Booth

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: William A. Jackson

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cardio-vascular Disease (chronic)	unknown
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last — 422.1 93d	(b) Arteriosclerosis	"
	(c) Senility	

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
John M. Slaby M.D., Deputy Medical Examiner, Annapolis, Md. 5-18-49.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: May 22 49
NAME OF CEMETERY OR CREMATORY: Furnace Branch
LOCATION (City, town, or county) (State): A A Co Md

DATE REC'D BY LOCAL REG. 5/20/49
REGISTRAR'S SIGNATURE: Dan Hedrick
24. FUNERAL DIRECTOR: Isaac L Brown
ADDRESS: 1080 Montgomery St

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

114413

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Weems Creek; LENGTH OF STAY (in this place) MARYLAND; HOSPITAL OR INSTITUTION OR STREET ADDRESS Priest Farm Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis RURAL; STREET ADDRESS (If rural give location) Weems Creek Priest Farm Rd.

3. NAME OF DECEASED (Type or Print): (First) EMMA (Middle) C (Last) JACOBS

4. DATE OF DEATH: (Month) May (Day) 5, (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Aug 5 1870

9. AGE last birthday: 78 yrs. If under 1 year: Months 9, Days 0; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Ethel H Kohl

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocarditis Chr.	4 yrs
592 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	Several yrs
131a	(c) Chr. Interstitial Nephritis	Several yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1949, to May 5, 1949, that I last saw the deceased alive on May 5, 1949, and that death occurred at 4:30A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) George C Basil M.D ADDRESS Annapolis Md DATE SIGNED 5.6.49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial; DATE THEREOF 5-7-49; NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery; LOCATION (City, town, or county) (State) Annapolis, Md

DATE REC'D BY LOCAL REG. May 7, 1949; REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR ADDRESS Ben L. Hopping and Son Annapolis, Md

VS. A15

RECEIVED
MAY 12 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

104414

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis | LENGTH OF STAY (in this place) 23 Yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Carroll Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis, Maryland
STREET ADDRESS (If rural give location) 15 Carroll Street

3. NAME OF DECEASED (Type or Print): (First) Ida (Middle) Dorsey (Last) Jacobs
4. DATE OF DEATH: (Month) 5 (Day) 17 (Year) 1949

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married
8. DATE OF BIRTH: 4/30/1882
9. AGE last birthday: 67 yrs. If under 1 year: Months ___ Days ___ If under 24 hrs.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Anne Arundel, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Abraham Dorsey
14. MOTHER'S MAIDEN NAME: Unlnown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Albert Jacobs

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Malnutrition

306 Antecedent cause(s)

91 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic Dementia

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) Annapolis | (COUNTY) aa | (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-21, 1949, to 5-17, 1949, that I last saw the deceased alive on 5-16, 1949, and that death occurred at 1:35 A.m., from the causes and on the date stated above.

SIGNATURE E. T. Allen | (Degree or title) MD | ADDRESS 10 Carroll St | DATE SIGNED 5-17-49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE 5/20/1949 | NAME OF CEMETERY OR CREMATORY Mt. Auburn | LOCATION (City, town, or county) Baltimore, Maryland (State)

DATE REC'D BY LOCAL REG. 5/20/49 | REGISTRAR'S SIGNATURE [illegible] O'Donnell

24. FUNERAL DIRECTOR Mrs. Charles E. Hicks-43-45 | ADDRESS Northwest St.

RECEIVED
MAY 21 1949
BUREAU V. S.

04415

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH: COUNTY Anne Arundle MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Crownsville
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Crownsville
STREET ADDRESS (If rural give location) A A Co

3. NAME OF DECEASED (Type or Print) (First) Emma (Middle) A (Last) Jager

4. DATE OF DEATH (Month) May (Day) 29 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Feb 20-1867
9. AGE last birthday 82 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Md
12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME Thomas Jones
14. MOTHER'S MAIDEN NAME Amelia Read

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Margaret Baldwin

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH 5 years

4222 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

93d (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 20, 1948, to May 29, 1949, that I last saw the deceased alive on May 28, 1949, and that death occurred at 1:15 A m., from the causes and on the date stated above.

SIGNATURE Robert S McCurney (Degree or title) MD ADDRESS Laurel Md DATE SIGNED 5/29/49

23. BURIAL, CREMATION REMOVAL (Specify) DATE THEREOF June 1-49 NAME OF CEMETERY OR CREMATORY Loudon Park LOCATION (City, town, or county) Balto (State) Md

DATE REC'D BY LOCAL REG. May 30/49 REGISTRAR'S SIGNATURE Clara Heaslup
24. FUNERAL DIRECTOR M Fladung Sons ADDRESS Bowie Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 8 1949
BUREAU V. S.

04416

MARYLAND STATE DEPARTMENT OF HEALTH

2411 Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville, Md.
LENGTH OF STAY (in this place) 4 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Prince George's COUNTY Md.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Seat Pleasant D. C.
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) JOSEPH (Middle) JON (Last) ES
4. DATE OF DEATH (Month) 5 (Day) 7 (Year) 1949
5. SEX Male
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single
8. DATE OF BIRTH 6-26-1929
9. AGE last birthday 19 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Washington, D. C.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME unknown
14. MOTHER'S MAIDEN NAME Elizabeth Contee
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pneumonia	1 day
325.5 Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Progressive muscle dystrophy(Erb)	known to us
109	(c) Mental Deficiency	since 9/8/1944

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) no
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/8/, 1944, to 5/7, 1949, that I last saw the deceased alive on 5/7, 1949, and that death occurred at 10 a.m., from the causes and on the date stated above.

SIGNATURE Jacob Morgenstern M.D. (Degree or title) ADDRESS Crownsville DATE SIGNED 5/8.49

23. BURIAL, CREMATION, REMOVAL (Specify) DATE 5/8.49 NAME OF CEMETERY OR CREMATORY Wash DC. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. 5/8.49 REGISTRAR'S SIGNATURE E. F. Joyce Local Reg
24. FUNERAL DIRECTOR Henry S. Washington ADDRESS Wash. Dct. 467 N St N. W.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
MAY 11 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

04417

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Anne Arundel; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis; LENGTH OF STAY (in this place): 30 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS: 121 West Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis, ; STREET ADDRESS (If rural give location): 121 West St.

3. NAME OF DECEASED (Type or Print): (First) Mattey (Middle) Estelle (Last) King

4. DATE OF DEATH: (Month) May (Day) 25, (Year) 1949

5. SEX: Female

6. COLOR OR RACE: Whtie

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Oct. 2, 1884

9. AGE last birthday: 65 yrs. If under 1 year: Months 7, Days 23; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during ~~most of~~ working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY: ------

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William F. Leitch

14. MOTHER'S MAIDEN NAME: Sarah Jane Wells

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mr. Josephh W King

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Thrombosis — Instantaneous

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hard Coronary infarct 2½ mos. ago

420.1
61

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 1, 19 49 to May 25, 19 49, that I last saw the deceased alive on May 17, 19 49, and that death occurred at 8 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Marvin J. Hammond, MD — ADDRESS: 31 Southgate Ave., Annapolis, Md — DATE SIGNED: 5/20/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: May 28, 1949 — NAME OF CEMETERY OR CREMATORY: Edwards Chapel — LOCATION (City, town, or county) (State): Riva Rd. Annapolis, Md.

DATE REC'D BY LOCAL REG.: May 27, 1949 — REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR: B.L. Hopping and Son — ADDRESS: Annapolis, Maryla

RECEIVED
JUN 1 1949
BUREAU V. S.

EVIDENCE FOR CHANGE OF AGE ISON:

FILM No. G 120 JUN -1 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Bc 04418

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Balt. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville — LENGTH OF STAY (in this place) 2 yr, 9 mos. 6 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore, Maryland
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital	STREET ADDRESS (If rural, give location) 308 North Pine Street

3. NAME OF DECEASED (Type or Print)	(First) Fred	(Middle)	(Last) MacDonald	4. DATE OF DEATH	(Month) 5/17/49 (Day) (Year) 19
5. SEX male	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH 5/18/19	9. AGE last birthday ~~30~~ 29 yrs.	If under 1 year ~~Months~~ ~~Days~~ If under 24 hrs. ~~Hours~~ ~~Min.~~
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) South Carolina	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Charles McDonald	14. MOTHER'S MAIDEN NAME Mamie Jones				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If war, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT Hospital Records			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
002 Immediate cause	(a) Miliary Tuberculosis of the Lungs	known since 5/16/49
130 Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) Schizophrenia, Paranoid Type	known since 8/12/46

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION ****** 19b. MAJOR FINDINGS OF OPERATION ********** 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) ****** PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ********** (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) ********** INJURY OCCURRED While at Work ☐ Not While At work ☐ ****** HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/12/46, 19....., to 5/17/49, 19....., that I last saw the deceased alive on 5/17/49, 19....., and that death occurred at 6:50 P.M. m., from the causes and on the date stated above.

SIGNATURE Jacob Morgenstern M.D. (Degree or title) ADDRESS Crownsville, Maryland DATE SIGNED 5/17/49

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE 5/26.49 NAME OF CEMETERY ~~OR CREMATORY~~ Hospital LOCATION (City, town, or county) Crownsville Md (State)

DATE REC'D BY LOCAL REG. 5 26 49 REGISTRAR'S SIGNATURE E.F. Joyce Local Reg. 24. FUNERAL DIRECTOR Supt. Hospital ADDRESS Crownsville Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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T

RECEIVED
MAY 27 1949
BUREAU V. S.

~~B. #'s~~ Death 04419

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF ~~STILLBIRTH~~

Reg. Dist. No. 28

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

M C

1. PLACE OF BIRTH:
   County: Anne Arundel
   City or town: Rural - odenton
   (If outside city or town limits, write RURAL and give nearest town)
   Street address, hospital, or institution:
   Length of mother's stay in County: 24 yrs
   (How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:
   State: Maryland
   County: Anne Arundel
   City or town: Rural - odenton
   (If outside city or town limits, write RURAL and give nearest town)
   Street No.
   (If RURAL give LOCATION)

3. Name of child: Not Named
4. Date of birth: May 31 1949 Hour: 6 15 P.M.
5. Sex: Male
6. Twin or triplet: No
7. No. of weeks pregnancy: 28

Child Lived 15 Hours

I

FATHER OF CHILD

8. Full name: George Edward Mauk
9. Color: B
10. Age at time of this birth: 25 yrs.
11. Usual occupation: Truck Driver

MOTHER OF CHILD

12. Full maiden name: Helen Pauline Brown
13. Color: B
14. Age at time of this birth: 24 yrs.
15. Usual occupation: House wife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 3
    (b) How many other children were born alive but are now dead? 0 (c) How many other children were *born* dead? 0

17. Did child die before labor? No During labor? No
18. Pregnancy, complications of: None
19. Labor: (a) Complications of: Premature labor (b) Induced?
20. (a) Was there an operation for delivery? No (Yes or No)
    (b) State all operations, if any
    (c) Did child die before operation? —
    During operation? —

21. Cause of ~~stillbirth~~ Death. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.
    (a) Fetal causes: Prematurity
    (b) Maternal causes

776/59

22. I certify to the birth of this child who was born ~~dead~~* on the date and hour above stated.
    Signature: Edward J Hewitt M.D.
    (Specify if M. D., midwife, or other)
    Address: Edmonds Md

23. (a) buried (Burial, cremation or removal) (b) Date thereof 4/2-49 (month) (day) (year)
    (c) Cemetery or ~~crematory~~: John Wesley Church

24. (a) Funeral director: Berg Johnson
    (b) Address: Odenton

25. (a) 4/2/49 (Date rec'd by registrar) (b) E. Z. Joyce (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.
    Health Officer, per

V. S. A10

T

* See Instruction C on stub.

RECEIVED
JUN 6 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

044210

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hyattsville; LENGTH OF STAY (in this place) Summer home
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia; COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 2702 Ontario Road N.W. ✓

3. NAME OF DECEASED (Type or Print): (First) Ronald (Middle) Stewart (Last) MacLaren
4. DATE OF DEATH: (Month) May (Day) 21 (Year) 1949
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: July 5, 1877
9. AGE last birthday: 71 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Builder
10b. KIND OF BUSINESS OR INDUSTRY: Building homes
11. BIRTHPLACE (State or foreign country): Muskegan
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: Donald MacLaren
14. MOTHER'S MAIDEN NAME: unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY No.:
17. INFORMANT: Mrs. Ronald S. MacLaren

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage — sudden

331 / 8 30 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Arterial hypertension — unknown
(c) General Arterio-sclerosis — unknown

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John M. Cliffy M.D.; Deputy Medical Examiner, Annapolis, Md. 5-21-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: May 24, 1949 | NAME OF CEMETERY OR CREMATORY: Cedar Hill | LOCATION (City, town, or county) (State): Suitland, Md.

DATE REC'D BY LOCAL REG: May 21 49 | REGISTRAR'S SIGNATURE: J. B. Dent.

24. FUNERAL DIRECTOR: W. W. Taltonnell | ADDRESS: 3619-14th St NW Wash. D.C.

RECEIVED
MAY 24 1949
BUREAU V. S.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04421

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Laurel
LENGTH OF STAY (in this place) 11 years 3 mo 23 d
HOSPITAL OR INSTITUTION OR STREET ADDRESS District Training

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Washington D.C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington D.C.
STREET ADDRESS (If rural give location) 909 4th St. N.W.

3. NAME OF DECEASED (Type or Print) (First) Robert (Middle) (Last) Marini

4. DATE OF DEATH (Month) May (Day) 14 (Year) 1949

5. SEX M
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single
8. DATE OF BIRTH April 9, 1932
9. AGE last birthday 17 yrs. If under 1 year: Months — Days — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10b. KIND OF BUSINESS OR INDUSTRY single
11. BIRTHPLACE (State or foreign country) Washington D.C.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Mareno Marini
14. MOTHER'S MAIDEN NAME Clara

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT D.T.S.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Lung abscesses (multiple) — INTERVAL BETWEEN ONSET AND DEATH: 14 days

521

Antecedent cause(s)

157a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hydrocephalus, spastic quadriplegia, idiocy — since birth

19a. DATE OF OPERATION none
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1946, to May 14, 1949, that I last saw the deceased alive on May 14, 1949, and that death occurred at 2 30 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS D.T.S. Laurel, Md. J. A. Alston, MD. DATE SIGNED 5-14-49

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE 5-17-49 NAME OF CEMETERY OR CREMATORY Mt. Olivet. Wash. D.C. LOCATION (City, town, or county) Wash. D.C. (State)

DATE REC'D BY LOCAL REG. May 16-49 REGISTRAR'S SIGNATURE Clara Haslup
24. FUNERAL DIRECTOR Timothy Hanlon ADDRESS

RECEIVED
JUN 9 1949
BUREAU V. S.

04422

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 20

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN (Road River) Mayo
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Washington, D.C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 700 12th St. S.E.
STREET ADDRESS (If rural, give location) Washington, D.C.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Lloyd Elwood Martin Jr.

4. DATE OF DEATH (Month) (Day) (Year) May 22, 1949 19

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH 2-18-26
9. AGE last birthday 23 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver
10b. KIND OF BUSINESS OR INDUSTRY US Gov.
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Lloyd E. Martin Sr.
14. MOTHER'S MAIDEN NAME Alice R. Ridgeway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes, (If yes, give war or dates of service) W.W. II
16. SOCIAL SECURITY NO.
17. INFORMANT Brother; George Martin

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Drowning

929.8 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Accidental

183

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (Road River) (CITY OR TOWN) Mayo (COUNTY) Anne Arundel (STATE) Maryland
TIME OF INJURY (Month) (Day) (Year) (Hour) May 22, 1949 5:45 P.m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Dove over board on Rescue Mission

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Caffy Md (Degree or title) Deputy Medical Examiner ADDRESS Annapolis, Md DATE SIGNED 5-23-49

23. BURIAL, CREMATION, REMOVAL (Specify) Removal
DATE THEREOF May 23, 1949
NAME OF CEMETERY OR CREMATORY to
LOCATION (City, town, or county) (State) Washington, D.C.

DATE REC'D BY LOCAL REG. May 23, 1949
REGISTRAR'S SIGNATURE Edward Collenson
24. FUNERAL DIRECTOR W.W. Chambers ADDRESS Washington, D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
MAY 31 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01123

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: ANNE ARUNDEL

City or town: ~~Gl~~ FERNDALE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: ANNE ARUNDEL

City or town: GLT FERNDALE
(If outside city or town limits, write RURAL and give nearest town)

Street No. 109 Wellham Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

JOHN RUBIN MASON, SR

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: Ruth Mason
NEE RUBLE

6.(c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.): July 11, 1883

8. AGE:	Years	Months	Days	If less than one day
	65			....hrs. ....min.

9. Birthplace: CALLAWAY, FRANKLIN Co. VA.
(Town, county, and state)

10. Usual occupation: C&AL BUSINESS

11. Industry or business: OWN BUSINESS

FATHER
12. Name: JOHN N. MASON
13. Birthplace: ———

MOTHER
14. Maiden name: PRUDENCE A. PRICE
15. Birthplace: ———

16. Informant: Mrs. J. R. Mason, Sr.
Address: 109 Wellham Ave. FERNDALE, MD.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: May 9, 1949 (month) (day) (year)

Cemetery or crematory: GLEN HAVEN

Location: GLEN BURNIE, MD.

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md.

19. 5/8 1949 (Date rec'd by registrar) L. J. De Alba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6 1949 at 10:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1948, to May 6 1949 and that I last saw him alive on May 6 1949

Immediate cause of death	DURATION
Cardia failure	9 mo.
Due to Degenerative Cardio-Vascular Disease	3 years
Due to	
Other conditions: Cirrhosis liver	

422.1
124b
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. Brady Smith, M.D.
M. D. or other

Address: RIVIERA BEACH, MD Date signed 5/6/49

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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RECEIVED
MAY 10 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

11424

Reg. Dist. No. 25

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Brooklyn
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 5515 Magie Street

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Brooklyn
STREET ADDRESS (If rural, give location): 5515 Magie Street

3. NAME OF DECEASED (Type or Print): (First) Alice (Middle) Leona (Last) McCarty

4. DATE OF DEATH: (Month) May (Day) 2, (Year) 1949

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Oct. 7, 1905

9. AGE last birthday: 43 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Roland Howeth

14. MOTHER'S MAIDEN NAME: Lula Short

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Lula Phillips, 5515 Magie Street

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

199.8 **Immediate cause** (a) Carcinoma of Pelvis uterus & Bladder

48b **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH:

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour): m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 1, 1949, to May 2, 1949, that I last saw the deceased alive on May 1, 1949, and that death occurred at 19 m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Thos. H. Phillips 3307 Edmondson Ave — ADDRESS — DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 5/4/49 — NAME OF CEMETERY OR CREMATORY: Cedar Hill — LOCATION (City, town, or county) (State): Anne Arundel County, Maryland

DATE REC'D BY LOCAL REG.: 5/3/49 — REGISTRAR'S SIGNATURE: A. W. Hedrick

24. FUNERAL DIRECTOR — ADDRESS: Wm. Cook, Inc., 1217 St. Paul Street

98

04425

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parole
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) George (Middle) (Last) McGowan

4. DATE OF DEATH (Month) May (Day) 3 (Year) 1949

5. SEX Male
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed
8. DATE OF BIRTH Jan. 14, 1884
9. AGE last birthday 65 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Calvert Co. Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Jacob McGowan
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Georgianna McGowan

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 2½ Wks.

331 Antecedent cause(s)

83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION none.
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19...., to May 3, 1949, that I last saw the deceased alive on May 2, 1949, and that death occurred at 6 A.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Maurice F. Klawans, Md 31 Smithgate Av. Annapolis Md

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE May 6, 1949
NAME OF CEMETERY OR CREMATORY Chews Chapel
LOCATION (City, town, or county) Owensville (State) Md.

DATE REC'D BY LOCAL REG. May 6, 1949
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR F.B. Johnson ADDRESS Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
MAY 9 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

04426

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville; LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore

STREET ADDRESS (If rural, give location) 213 West Biddle

3. NAME OF DECEASED (Type or Print): (First) WILLIAM (Middle) MURRAY (Last) SR.

4. DATE OF DEATH: (Month) 5 (Day) 3 (Year) 19 49

5. SEX: male

6. COLOR OR RACE: negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 1926

9. AGE last birthday: 23 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Murray Sr.

14. MOTHER'S MAIDEN NAME: Lulu Price

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service): ?

16. SOCIAL SECURITY No.:

17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Homicide Brain Concussion — 20 Minutes

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Subarachnoidal Bleeding

983 169

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☑ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Hospital

(CITY OR TOWN) Crownsville (COUNTY) A. A. (STATE) Md.

TIME OF INJURY (Month) May (Day) 3 (Year) 1949 (Hour) 7 A.m.

INJURY OCCURRED While at work ☐ Not while at work ☑

HOW DID INJURY OCCUR? In criminal ward at Hospital

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: John M. Caffey M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md. DATE SIGNED 5-3-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE THEREOF 5-7-49 NAME OF CEMETERY OR CREMATORY Mt. Calvary LOCATION (City, town, or county) A. A. Co. (State) Md.

DATE REC'D BY LOCAL REG. 5/4/49 REGISTRAR'S SIGNATURE A. W. Hedrick

24. FUNERAL DIRECTOR A. Halstead ADDRESS 918 Edmondson Ave

A. HALSTEAD.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04427 23

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN No. Linthicum
LENGTH OF STAY (in this place) 1 yr.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 214 Charles Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN North Linthicum
STREET ADDRESS (If rural, give location) 214 Charles Road

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) Ellen (Last) Orem

4. DATE OF DEATH (Month) May (Day) 10 (Year) 1949

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow

8. DATE OF BIRTH 6/8/54

9. AGE last birthday 94 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME James Forrest.

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY No. None

17. INFORMANT Mrs. Catherine Sheppard

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cardio-Vascular Disease	2 yrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterio-Sclerosis	15 yrs.
	(c)	

422.1
93d

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb., 1947, to 5/10, 1949, that I last saw the deceased alive on 5/10, 1949, and that death occurred at 11:45 P m., from the causes and on the date stated above.

SIGNATURE Chas. L. Ball (Degree or title) Jr. MD ADDRESS Linthicum DATE SIGNED 5/10/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF 5/14/49

NAME OF CEMETERY OR CREMATORY Loudon Park Cem.

LOCATION (City, town, or county) (State) Balto., Md.

DATE REC'D BY LOCAL REG. 5/12/49

REGISTRAR'S SIGNATURE W. W. Hedrick

24. FUNERAL DIRECTOR WM. J. TICKNER & SONS - ADDRESS Balto., Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1949
5
5

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

04428

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ruggetty Road Rt. 2 Box 2-C-Lancaster | LENGTH OF STAY (In this place) 2 Yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS St. Ann's Spiritual Temple.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parole
STREET ADDRESS (If rural, give location) Simms' Crossing.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Alexander		Parker Jr.	May	13	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
M.	Black		April-1877	72 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Maryland.	U.S.A.

13. FATHER'S NAME: Alexander Parker - Sr.
14. MOTHER'S MAIDEN NAME: Unknown.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	214120813	Mrs. Margaret Stepney (daughter).

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Occlusion	Sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

420.1
940

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Gustave H. Parker M.D.	(Assistant Medical Examiner)	Glen Burnie, Md.	5/15/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5/20/1949	Mt. Arburn Cemetery	Baltimore, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
May 17, 1949	[signature]	Mrs. Charles E. Hicks	43-45 Northwest St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
MAY 18 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04429

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville; LENGTH OF STAY (in this place) 3 yr. 5 mo. 5 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE; COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore, Maryland; STREET ADDRESS (If rural, give location) 1603 Madison Avenue

3. NAME OF DECEASED (Type or Print): (First) SOPHIE (Middle) (Last) PARKER

4. DATE OF DEATH: (Month) 5 (Day) 31 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 1860?

9. AGE last birthday: 89? yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: -----

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: -----

14. MOTHER'S MAIDEN NAME: -----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.2 **Immediate cause** (a) Chronic Myocarditis — Known to us since — Interval Between Onset and Death: 3/1/49-2mo.

Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) Senile Psychosis — Known to us since — 2/25/46

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: -----

19b. MAJOR FINDINGS OF OPERATION: -----

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): -----

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Hospital — (CITY OR TOWN) Crownsville — (COUNTY) Anne Arundel — (STATE) Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): ----- m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?: -----

22. I hereby certify that I attended the deceased from 2/25, 1946, to 5/31, 1949, that I last saw the deceased alive on 5/31, 1949, and that death occurred at 4 P. m., from the causes and on the date stated above.

SIGNATURE Jacob Morgenstern (Degree or title) M.D. ADDRESS DATE SIGNED 5/31/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE June 5 1949 — NAME OF CEMETERY OR CREMATORY Catonsville Mem. Pk. — LOCATION (City, town, or county) Balto. Co. — (State) Md.

DATE REC'D BY LOCAL REG. 6/5/49 — REGISTRAR'S SIGNATURE City Health Dept. T.. — 24. FUNERAL DIRECTOR Holland Funeral Home — ADDRESS 1631 West Fayette Ave.

May 3692

RECEIVED
JUN 7 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04430

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 81 Calvert St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 81 Calvert St.

3. NAME OF DECEASED (Type or Print): (First) Alice (Middle) (Last) Pinkney

4. DATE OF DEATH: (Month) May (Day) 30 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: May 7, 1893

9. AGE last birthday: 56 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Annapolis

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Scott

14. MOTHER'S MAIDEN NAME: Eliza Duckett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: London Pinkney

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Hypertensive Cardio Vascular Disease — 6 days.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

448
938

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION: None

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): No

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 3, 1948, to May 31, 1949, that I last saw the deceased alive on May 31, 1949, and that death occurred at 12:10 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Theodore L. Johnson M.D. 40 Northwest Street Annapolis, Md 6/1/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 6-2-49

NAME OF CEMETERY OR CREMATORY: Brewer Hill

LOCATION (City, town, or county) (State): Annapolis Md.

DATE REC'D BY LOCAL REG.: June 2, 1949

REGISTRAR'S SIGNATURE: Mrs. D. Brush

24. FUNERAL DIRECTOR: William Keene II

ADDRESS: 108 Prince George St Annapolis, Md

RECEIVED
JUN 3 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04431

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie
LENGTH OF STAY (in this place) 25 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie
STREET ADDRESS (If rural give location) 18 Georgia Ave.

3. NAME OF DECEASED (Type or Print) (First) FRANK (Middle) X (Last) REZAC

4. DATE OF DEATH (Month) May (Day) 11 (Year) 1949

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH Jan 23, 1883

9. AGE last birthday 66 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor

10b. KIND OF BUSINESS OR INDUSTRY Krohl Tailoring

11. BIRTHPLACE (State or foreign country) Austria

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Vincent Rezac

14. MOTHER'S MAIDEN NAME Frances (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO. 212 10 7959

17. INFORMANT Charles Rezac

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) CORONARY THROMBOSIS

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ARTERIOSCLEROSIS GENERALIZED

94a (c) NONE

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. NONE

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from FEB, 1949, to MAY, 1949, that I last saw the deceased alive on MAY 4, 1949, and that death occurred at 1 a. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Henry F. Zangara M.D. May 11, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF May 13, 49

NAME OF CEMETERY OR CREMATORY Holy Cross

LOCATION (City, town, or county) (State) Cedar Hill, Brooklyn, Md.

DATE REC'D BY LOCAL REG. 5/12

REGISTRAR'S SIGNATURE L. J. De Alba

24. FUNERAL DIRECTOR Thomas W. Singleton ADDRESS Glen Burnie, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 14 1949
BUREAU U. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

014432

Reg. Dist. No. 2/

1. PLACE OF DEATH
COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Robinson Station
LENGTH OF STAY (In this place):
~~HOSPITAL OR~~ INSTITUTION OR STREET ADDRESS: Severna Park

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Robinson Station
STREET ADDRESS (If rural, give location): Severna Park

3. NAME OF DECEASED (Type or Print): (First) Lizzie (Middle) H. (Last) Robinson

4. DATE OF DEATH: (Month) May (Day) 6 (Year) 1949

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: November 10, 1863

9. AGE last birthday: 85 yrs.
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Marley, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Joseph Hodges

14. MOTHER'S MAIDEN NAME: Annie Hunt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Laura E. Robinson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardio-Vascular Disease — 4 hrs.

422.1 93d

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cerebro - sclerosis — 10 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19 45, to 5/6/49, that I last saw the deceased alive on 5/6/49, and that death occurred at 5:15 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Chas. L. Ball Jr. MD Linthicum 5/6/49.

23. BURIAL, CREMATION REMOVAL (Specify): burial

DATE THEREOF: 5-9-49

NAME OF CEMETERY OR CREMATORY: Cedar Hill

LOCATION (City, town, or county) (State): Brooklyn, Md.

DATE REC'D BY LOCAL REG. 5/9/49

REGISTRAR'S SIGNATURE: Alw. Hedrick

24. FUNERAL DIRECTOR: John O. Mitchell & Sons, Inc.

ADDRESS: 1900 Eutaw Pl

Dr Basil

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04433

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
STREET ADDRESS (If rural, give location) 541 Second

3. NAME OF DECEASED (Type or Print): (First) EDNA (Middle) (Last) ROGERS

4. DATE OF DEATH: (Month) 5 (Day) 8 (Year) 1949

5. SEX: F.

6. COLOR OR RACE: W.

7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~, (Specify)

8. DATE OF BIRTH: MAY-8-1905

9. AGE last birthday: 44 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): CHURCHTON AAC MD

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: JOHN FORD

14. MOTHER'S MAIDEN NAME: MARGARET ROGERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT: J. W. FULTON ROGERS

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute Myocarditis	3 weeks
444 Antecedent cause(s)	(b) Chr Interstitial Nephritis	2 yrs
131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Hypertension	4 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 20, 1949, to May 8, 1949, that I last saw the deceased alive on May 8, 1949, and that death occurred at 9 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

George C Basil M D Campbell Mo 5-10-49

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) DATE 5-11-49 NAME OF CEMETERY OR CREMATORY GLEN HAVEN LOCATION (City, town, or county) GLEN BURNIE (State) MD

DATE REC'D BY LOCAL REG. May 11, 1949

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR JOHN M. TAYLOR-SON ADDRESS ANNAPOLIS MD

VS. A15

RECEIVED
MAY 12 1949
BUREAU V. S.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04434

Reg. Dist. No. 26

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Shadyside — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Shadyside
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Leonard (Middle) A. (Last) Rogers	4. DATE OF DEATH (Month) May (Day) 12, (Year) 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Male	White	married	May 12,1905	44 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Boat-Builder	Boat-yard	Shadyside, Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Robert Rogers	Elizabeth Atwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no			Mrs. Leonard A. Rogers

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinoma stomach — 6 months

151 Antecedent cause(s)

46b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 12-3-, 1946, to May 8, 1949, that I last saw the deceased alive on May 8, 1949, and that death occurred at 10 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Herbert Thomson, M D — ADDRESS 915-19-11 W. Wash DC — DATE SIGNED 5/13/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	May14,1949	Woodfields	Galesville Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
May 14	J. B. Dent	T.A.Hardesty & Son	Galesville, Md

RECEIVED
MAY 17 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

04435

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis; LENGTH OF STAY (In this place) Dead on arrive; HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold; STREET ADDRESS (If rural, give location) Joyce's Lane

3. NAME OF DECEASED (Type or Print): (First) Jerome (Middle) ARTHUR (Last) Scott

4. DATE OF DEATH: (Month) May (Day) 28 (Year) 1949

5. SEX: male

6. COLOR OR RACE: negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: 6-2-48

9. AGE last birthday: 11 months; If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Scott

14. MOTHER'S MAIDEN NAME: Rozetta Day

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Irene Day

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Asphyxia

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Regurgitated vomitus

(c) Accidental

92.10
195d

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Home

(CITY OR TOWN) Arnold (COUNTY) A.A. (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) May 28, 1949 4 P.M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John N. Caffy M.D., Deputy Medical Examiner Annapolis Md 5-28-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF May 30 1949

NAME OF CEMETERY OR CREMATORY Mt Calvary

LOCATION (City, town, or county) Arnolds (State) Md

DATE REC'D BY LOCAL REG. May 30, 1949

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR J. B. Johnson

ADDRESS Annapolis

VS. A15A

RECEIVED
JUN 1 1949
BUREAU V. S.

Jerome Arthur Scott was born June 2, 1948 according to our copy of his birth certificate.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

04436

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY IN this place
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parole
STREET ADDRESS (If rural, give location) Defense Highway

3. NAME OF DECEASED (Type or Print): (First) Milford (Middle) Frank (Last) Sears

4. DATE OF DEATH: (Month) May (Day) 1 (Year) 1949

5. SEX male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widower | 8. DATE OF BIRTH Apr. 21, 1878 | 9. AGE last birthday 71 yrs. | If under 1 year: Months 0 Days 18 | If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dairy Farmer | 10b. KIND OF BUSINESS OR INDUSTRY Florist Gardner | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME John Wesley Sears | 14. MOTHER'S MAIDEN NAME Mary E. Phipps

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) State Militia | 16. SOCIAL SECURITY NO. 219-01-9625 | 17. INFORMANT Charles F. Sears

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)	Coronary occlusion	Sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	Coronary sclerosis	Unknown
(c)	Arterial Hypertension	Unknown

420.1 94a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John M. Cattell M.D. Deputy Medical Examiner Annapolis Md 5/1/49

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF 5-4-49 | NAME OF CEMETERY OR CREMATORY Cedar Bluff | LOCATION (City, town, or county) (State) Annapolis, Md.

DATE REC'D BY LOCAL REG. May 2, 1949 | REGISTRAR'S SIGNATURE | FUNERAL DIRECTOR AND ADDRESS B. L. Hopping and Son Annapolis, Md.

VS. A15A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
MAY 4 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01137

Reg. Diat. No. 25

1. PLACE OF DEATH:

County A.A.

City or town Solly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A.A.

City or town Solly

(If outside city or town limits, write RURAL and give nearest town)

Street No. Solly Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME JOHN SEIDEL

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife Carolina Knott

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 12/22/1865

8. AGE: Years	Months	Days	If less than one day
83	5	6	....hrs. ....min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name UNK.

13. Birthplace GERMANY

MOTHER 14. Maiden name UNK.

15. Birthplace GERMANY

16. Informant Family

Address Same

17. B (Burial, cremation, or removal. Which?) Date thereof 6/1/49 (month) (day) (year)

Cemetery or crematory Holy Cross

Location Brooklyn

18. Funeral director [illegible] L. McCarty

Address 130 East Fort Avenue

19. May 31 19 49 Edna M. Wheeler

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 19 49, at 5:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 49 to May 28 19 49

and that I last saw h. l. M. alive on May 25 19 49

Immediate cause of death Heart Failure

	DURATION
Due to Degenerative Cardio-Vascular Disease	5 years
Due to 443 Hypertension Cardio Vascular Disease	5 years
Other conditions 930	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Bradley Smith M.D.

M. D. or other

Address Riviera Beach Md. Date signed 5/28/49

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 1 1949
BUREAU V. S.

04438

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH · COUNTY A. A. Co. MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn Park — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn Park
HOSPITAL OR INSTITUTION OR STREET ADDRESS 215 Meadow Rd.	STREET ADDRESS (If rural, give location) 215 Meadow Rd.

3. NAME OF DECEASED (Type or Print)	(First) EDGAR	(Middle) H.	(Last) SHOWACRE	4. DATE OF DEATH	(Month) May	(Day) 10	(Year) 1949
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Dec. 14, 1884	9. AGE last birthday 64 yrs.	If under 1 year Months	Days	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clergyman - retired	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME George W. Showacre			14. MOTHER'S MAIDEN NAME Christiana Harrison				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. no		17. INFORMANT Mrs. Elsie M. Showacre - Brooklyn Pk. 215 Meadow Rd.				

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
581.0 Immediate cause	(a) Acute myocarditis	2
124 b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive cardio vascular disease	Acute
	(c) Chronic cirrhosis of liver	years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION none	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☒	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 3/8, 1949, to 5/10, 1949, that I last saw the deceased alive on 5/7, 1949, and that death occurred at 2:55 a.m., from the causes and on the date stated above.

SIGNATURE Stavig Deiler (Degree or title) M.D. ADDRESS DATE SIGNED 5/11/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF May 12 1949	NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.	LOCATION (City, town, or county) (State) Pikesville, Md.
DATE REC'D BY LOCAL REG. 5/12/49	REGISTRAR'S SIGNATURE H. W. Hedrick	24. FUNERAL DIRECTOR WM. J. TICKNER & SONS	ADDRESS Balto., Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04439

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
LENGTH OF STAY (in this place) ------
HOSPITAL OR INSTITUTION OR STREET ADDRESS Johnsons' Clinic

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eastport, near Annapolis
STREET ADDRESS (If rural give location) 139 Eastern Ave.

3. NAME OF DECEASED (Type or Print) (First) Richard (Middle) Birchard (Last) Simms, Jr.

4. DATE OF DEATH (Month) 5 (Day) 31 (Year) 1949

5. SEX Male
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) --------
8. DATE OF BIRTH 5-30-1949
9. AGE last birthday ----- yrs. If under 1 year: Months | Days | If under 24 hrs.: Hours 16 Min. 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? ----------

13. FATHER'S NAME Richard Birchard Simms
14. MOTHER'S MAIDEN NAME Helen Olivia Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) -----
16. SOCIAL SECURITY NO. None
17. INFORMANT Richard Birchard Simms

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Strangulation

461.5 Antecedent cause(s)

160c Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Prematurity

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-30, 1949, to 5-31, 1949, that I last saw the deceased alive on 5-31, 1949, and that death occurred at 9:30 A.m., from the causes and on the date stated above.

SIGNATURE A. T. Allen (Degree or title) M.D. ADDRESS 10 Carroll DATE SIGNED 5-31-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 6-1-1949
NAME OF CEMETERY OR CREMATORY Brewer Hill Cemetery
LOCATION (City, town, or county) (State) West St. Extended- Annapolis

DATE REC'D BY LOCAL REG. June 1, 1949
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR Mrs. Charles E. Hicks-43-45 ADDRESS Northwest St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 2 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

04440

Reg. Dist. No. 20

1. PLACE OF DEATH: COUNTY Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mayo (Rhode River) LENGTH OF STAY (in this place) ?
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington, D.C. Mayo
STREET ADDRESS (If rural, give location) 726 11th St. S.E.

3. NAME OF DECEASED (Type or Print) (First) Edward (Middle) Everett Eugene (Last) Soper
4. DATE OF DEATH (Month) May (Day) 22 (Year) 1949
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH March 1, 1926
9. AGE last birthday 23 yrs. If under 1 year: Months 3 Days 21 If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Washington D.C
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John E Soper
14. MOTHER'S MAIDEN NAME Emma Swann
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 758-26-7855
17. INFORMANT Mrs Emma Soper

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Drowning

929.8 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Accidental

183

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Rhode River (CITY OR TOWN) Mayo (COUNTY) Anne Arundel (STATE) Md.
TIME OF INJURY (Month) May (Day) 22, (Year) 1949 (Hour) 6 p.m.
INJURY OCCURRED While at work ☐ Not while at work ☑
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffy M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md. DATE SIGNED 5-22-49.

23. BURIAL, CREMATION REMOVAL (Specify) Removal
DATE THEREOF May 22, 1949
NAME OF CEMETERY OR CREMATORY To
LOCATION (City, town, or county) (State) Washington D.C.
DATE REC'D BY LOCAL REG. May 22, 1949
REGISTRAR'S SIGNATURE Edward Collenson
24. FUNERAL DIRECTOR J.T. Ryan Inc. ADDRESS Washington D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

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RECEIVED
MAY 31 1949
BUREAU V. S.

EVIDENCE FOR CHANGE OF ~~CHANGE OF~~ AGE IS ON!

04441

FILM No. G 120 JUN -1 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Balt. County
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville — LENGTH OF STAY (in this place) 4 mos. 10 days	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) not known
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital	STREET ADDRESS (If rural, give location) not known

3. NAME OF DECEASED (Type or Print)	(First) Lurvoyage	(Middle) Harrison	(Last) Starks	4. DATE OF DEATH (Month) 5/17/49 (Day) (Year) 19	
5. SEX male	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH 9/15/16	9. AGE last birthday ~~33~~ 32 yrs.	If under 1 year Months Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boatworker	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) New Jersey	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Daniel Starks	14. MOTHER'S MAIDEN NAME Not known				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Hospital Records			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) General Paresis	known since 1/7/49
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

025

30 b

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/7/49, 19....., to 5/17/49, 19....., that I last saw the deceased alive on 5/17/49, 19....., and that death occurred at 11:15 P.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Morgenstern	M.D.	Crownsville, Maryland	5/17/49

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify)	DATE 5/26 49	NAME OF CEMETERY ~~OR CREMATORY~~ HOSpital	LOCATION (City, town, or county) (State) Crownsville Md
DATE REC'D BY LOCAL REG. 5/26-49	REGISTRAR'S SIGNATURE E F Joyce L.Reg.	24. FUNERAL DIRECTOR Supt Hospital	ADDRESS Crownsville Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 27 1949
BUREAU V. S.

RECEIVED
MAY 27 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04442

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hosp. Annapolis Md

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville R.F.D.
STREET ADDRESS (If rural, give location) Whitneys South side of River

3. NAME OF DECEASED (Type or Print) (First) Elsie (Middle) E. (Last) Stinchcomb

4. DATE OF DEATH (Month) May (Day) 6 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. ~~SINGLE, MARRIED,~~ WIDOWED, ~~DIVORCED,~~ (Specify)
8. DATE OF BIRTH 1-23-1884
9. AGE last birthday [redacted] 65 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) A. A. Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Robert Moran
14. MOTHER'S MAIDEN NAME Mary Bell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Bernard Stinchcomb

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	1 hr.
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) arteriosclerotic cardio-vascular disease	10 yrs
	(c) bronchopneumonia et l. chest	1 wk

420.1
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 2, 1949, to May 6, 1949, that I last saw the deceased alive on May 6, 1949, and that death occurred at 7:30 p m., from the causes and on the date stated above.

SIGNATURE (Degree or title) S Borrsuch M.D. ADDRESS Annapolis Md DATE SIGNED 5/6/49

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE May 9th 1949 NAME OF CEMETERY OR CREMATORY Glen Haven LOCATION (City, town, or county) (State) Glen Burnie

DATE REC'D BY LOCAL REG. May 7, 1949 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR Thomas W. Singleton ADDRESS Glen Burnie Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 10 1949
BUREAU V. S.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04443

CERTIFICATE OF DEATH

Reg. Dist. No. 26

An. Ar.

1. PLACE OF DEATH: COUNTY Cedar Hurst Md - MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cedar Hurst
LENGTH OF STAY (in this place) 11 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Shadyside P.O.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Cedar Hurst COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural, give location) A A Co Md

3. NAME OF DECEASED (Type or Print) (First) JOHN (Middle) HENRY (Last) THOMAS

4. DATE OF DEATH (Month) May (Day) 1 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH Feb. 23, 1874
9. AGE last birthday 75 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railway Mail Clerk
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Unkown
14. MOTHER'S MAIDEN NAME Unkown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Mrs Wretha Mae Thomas

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 2 days

334 Antecedent cause(s)

83d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hemiplegia (left side) — 2 mos.

(c) Arteriosclerosis — ?

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 4, 1949, to May 1, 1949, that I last saw the deceased alive on May 1, 1949, and that death occurred at 4:45 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) B. S. John, M.D. ADDRESS 2325 Penn. Ave. N.W. Wash. D.C. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE May 4, 1949
NAME OF CEMETERY OR CREMATORY Cedar Hill
LOCATION (City, town, or county) (State) Washington D.C.

DATE REC'D BY LOCAL REG. May 1. 1949
REGISTRAR'S SIGNATURE J. B. Dent
24. FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS Riverdale Md

RECEIVED
MAY 3 1949
BUREAU V. S.

Evidence for change in age is shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04444

Bc

FILM No. G 121 JUL 12 1949

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH · COUNTY: A.A. MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Md. COUNTY: ------
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Jessups — LENGTH OF STAY (in this place): 7 mos.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Md. House of Correction	STREET ADDRESS (If rural give location): 905 Park Ave.

3. NAME OF DECEASED (Type or Print)	(First) Booker	(Middle) T.	(Last) Thompson	4. DATE OF DEATH	(Month) May	(Day) 21	(Year) 1949
5. SEX: Male	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): ----	8. DATE OF BIRTH: Aug. 2, 1907	9. AGE last birthday: 41 ~~42~~ yrs.	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor	10b. KIND OF BUSINESS OR INDUSTRY: Laborer	11. BIRTHPLACE (State or foreign country): Jackson, Mississippi	12. CITIZEN OF WHAT COUNTRY? U.S.				
13. FATHER'S NAME: -----	14. MOTHER'S MAIDEN NAME: ------						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.: 218-018248	17. INFORMANT: Patient					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

490 Immediate cause (a) Edema of Lungs — 3 days

Antecedent cause(s)

108 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Pneumonia, lobar bilateral

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 18, 1949, to May 21, 1949, that I last saw the deceased alive on May 21, 1949, and that death occurred at 8:30 P.m., from the causes and on the date stated above.

SIGNATURE: John A. Clark (Degree or title) — ADDRESS: John A. Clark M.D., Physician in Charge, -MHC-Jessups, Md. — DATE SIGNED: May 22, 1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE: June 20-49	NAME OF CEMETERY OR CREMATORY: Cherry Hill	LOCATION (City, town, or county): Jessup (State): Md
DATE REC'D BY LOCAL REG.: June 18-49	REGISTRAR'S SIGNATURE: Clara Haslup	24. FUNERAL DIRECTOR: H. L. Collins	ADDRESS: Jessup Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 6 1949
BUREAU V. S.

Dr Basil

04445

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Ann Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; STREET ADDRESS (If rural, give location) Route 1

3. NAME OF DECEASED (Type or Print): (First) LILLIE (Middle) K (Last) TITLOW

4. DATE OF DEATH: (Month) 5 (Day) 13 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Sept 16 1873

9. AGE last birthday: 75 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Frederick Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Harry Wisner

14. MOTHER'S MAIDEN NAME: Margaret Dennrich

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Harry Lambright

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Chr. Interstitial Nephritis	3 yrs
450.0 Antecedent cause(s)	(b) Arteriosclerosis	Unknown
131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Pyelitis	1 year

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept, 1948, to May 13, 1949, that I last saw the deceased alive on May 13, 1949, and that death occurred at 10 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

George C. Basil M.D. Annapolis Md 5-14-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: May 16 1949 | NAME OF CEMETERY OR CREMATORY: MT Olivet | LOCATION (City, town, or county) (State): Frederick Md.

DATE REC'D BY LOCAL REG. May 14, 1949 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR: Weaver Funeral Home | ADDRESS: 301 E. Capitol St Washington DC

VS. A15

RECEIVED
MAY 17 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04446

CERTIFICATE OF DEATH

Reg. Dist. No. 23

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY A. A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum
LENGTH OF STAY (In this place) 16 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 109 Hammonds Ferry Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum
STREET ADDRESS (If rural, give location) 109 Hammonds Ferry Rd.

3. NAME OF DECEASED (Type or Print): (First) George (Middle) Wesley (Last) Towers.

4. DATE OF DEATH: (Month) May (Day) 11 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 9/9/63

9. AGE last birthday: 85 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Asst. Parcel Post Post Office

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Wesley Towers. Sr.

14. MOTHER'S MAIDEN NAME: Caroline Hughlett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none.

17. INFORMANT: Grace L. Towers-109 Hammonds Ferry Rd Linthicum Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 **Immediate cause** (a) Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: April 9-49

93d **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterio-Sclerosis — 10 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 9, 1949, to May 11, 1949, that I last saw the deceased alive on May 11, 1949, and that death occurred at 4:00A m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Chas L. Ball J MD — ADDRESS: Linthicum — DATE SIGNED: 5/11/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: 5/14/49 — NAME OF CEMETERY OR CREMATORY: Lorraine Cem. — LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE REC'D BY LOCAL REG. 5/12/49 — REGISTRAR'S SIGNATURE: W. Hedrick

24. FUNERAL DIRECTOR: WM. J. TICKNER & SONS — ADDRESS: Balto., Md.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

B-C 04447

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Anne Arundel; MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Pasadena; LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ba ltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Powhaton Road	STREET ADDRESS (If rural, give location): 2000 Harlem Avve ✓

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	WILLIAM	LEE	TRUITT		May	1,	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Divorced	June 10, 1899	49 yrs.	10	15		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unemployed		Ocean City, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Shelly Truitt	Lillie Quillin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT
Yes W.W.I		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cardiac Failure	2 days
581.0 Antecedent cause(s)		
1240 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cirhosis Liver	1 year
	(c) Degenerative Cardio-Vascular Renal	1 year
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
No				

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from April 20, 1949, to May 1, 1949, that I last saw the deceased alive on April 30, 1949, and that death occurred at 1:55 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
J. Brady Smith	M.D.	Riviera Beach, Md.	

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5/4/49	National	Baltimore, Md.

DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
5-3-49	E. W. Kadrich	William Cook, Inc.,	1217 St. Paul St.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04448

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 212 Eastern Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport near Annapolis
STREET ADDRESS (If rural give location) 212 Eastern Ave.

3. NAME OF DECEASED (Type or Print): (First) Lottie (Middle) Jenkins (Last) Turner

4. DATE OF DEATH: (Month) 5 (Day) 10 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 11/12/1900

9. AGE last birthday: 48 yrs. If under 1 year: Months ___ Days ___ If under 24 hrs.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Philadelphia, Pa.

12. CITIZEN OF WHAT COUNTRY? ___

13. FATHER'S NAME: Oliver Coleman

14. MOTHER'S MAIDEN NAME: Betty Majors

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service) ___

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Israel Russel Turner

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Congestive Heart Failure — Interval Between Onset and Death: 3 yr 5 mos

434.1 Antecedent cause(s)

938 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ___

(c) ___

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION ___ 19b. MAJOR FINDINGS OF OPERATION ___ 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) ___ PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY ___ (CITY OR TOWN) annapolis (COUNTY) a a (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) m. ___ INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR? ___

22. I hereby certify that I attended the deceased from Dec 6, 1948, to May 10, 1949, that I last saw the deceased alive on May 9, 1949, and that death occurred at 4 10 A m., from the causes and on the date stated above.

SIGNATURE G. T. Allen (Degree or title) M D ADDRESS 16 Carroll DATE SIGNED 5-12-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE 5/14/1949 | NAME OF CEMETERY OR CREMATORY Brewer Hill Cemetery | LOCATION (City, town, or county) (State) West St. Extended- Annapolis

DATE REC'D BY LOCAL REG. May 10, 1949 | REGISTRAR'S SIGNATURE [signature] | 24. FUNERAL DIRECTOR ADDRESS Mrs. Charles E. Hicks-43-45 Northwest St.

RECEIVED
MAY 17 1949
BUREAU V. S.

Evidence for addition of sex color and marital status is on:

FILM No. G 120 JUN -6 1949

04449

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 25

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN White Oak Point, Pasadena
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn Park
STREET ADDRESS (If rural, give location) 131 Edgeville Road

3. NAME OF DECEASED (Type or Print) (First) Ronald (Middle) John (Last) Vollmer
4. DATE OF DEATH (Month) May (Day) 23 (Year) 1949
5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE
8. DATE OF BIRTH Aug. 20, 1944
9. AGE last birthday 4 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Maryland.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Robert William Vollmer
14. MOTHER'S MAIDEN NAME Agnes Smith
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT Frederick J. Vollmer

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Drowning

929.8 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Accidental

183

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Rock Creek (CITY OR TOWN) White Oak Point, Pasadena (COUNTY) A.A. (STATE) Md.
TIME OF INJURY (Month) May (Day) 23 (Year) 1949 (Hour) 3:00 p.m.
INJURY OCCURRED While at work ☐ Not while at work ☑
HOW DID INJURY OCCUR? Evidently fell off pier into water

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Caffy M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis, Md DATE SIGNED 5-23-49

23. BURIAL, CREMATION, REMOVAL (Specify) B. DATE THEREOF 5/27/49 NAME OF CEMETERY OR CREMATORY Cedar Hill LOCATION (City, town, or county) Brooklyn (State)

DATE REC'D BY LOCAL REG. May 23, 1949 REGISTRAR'S SIGNATURE Ida M. Whitson 24. FUNERAL DIRECTOR James L. McCully ADDRESS 130 E Fort Ave.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
MAY 31 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04450

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: A A Co

City or town: Glen Bernie (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: A A

City or town: Glen Bernie (If outside city or town limits, write RURAL and give nearest town)

Street No.: 8th Ave North Glenburnie A.A. Co. Md. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Anna M Wagner

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Jerome G Wagner

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): ~~May 31 1949~~ Sept 1 1915 ?

8. AGE:

Years	Months	Days	If less than one day
33	6	4	... hrs. ... min.

9. Birthplace: Balto Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: George Weinhold

13. Birthplace: Balto

MOTHER

14. Maiden name: Hannah Murr

15. Birthplace: Balto

16. Informant: Jerome G Wagner

Address: 8th Ave North

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6-4-49 (month) (day) (year)

Cemetery or crematory: A A Co Md Holy Cross

Location: Richie Hgyvy

18. Funeral director: EDWARD TOWLSON

Address: 2359 Washington Blvd

19. 6/3/49 19 (Date rec'd by registrar) A. W. Heinig Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 31st 1949 at 11:05 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 19 1948 to May 31st 1949 and that I last saw her alive on May 31st 1949

Immediate cause of death: Carcinoma of Colon — DURATION: 1 yr.

Due to: —

Due to: 153 / 462

Other conditions: None

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: P. J. Grimaldi M.D. (M. D. or other)

Address: 4609 Gov. Ritchie Hwy Date signed: 5-31-49

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04451

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md; MARYLAND; LENGTH OF STAY (In this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 30 Maryland Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md; STREET ADDRESS (If rural, give location) 30 Maryland Ave

3. NAME OF DECEASED (Type or Print): (First) Margaret (Middle) Cameron (Last) Walton

4. DATE OF DEATH: (Month) 5 (Day) 25 (Year) 1949

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, ~~MARRIED~~, WIDOWED, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH: 12-31-1871

9. AGE last birthday: 77 yrs. If under 1 year: Months. If under 24 hrs.: Days, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Music teacher

10b. KIND OF BUSINESS OR INDUSTRY: Piano.

11. BIRTHPLACE (State or foreign country): Norfolk Va

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Thomas L. Walton

14. MOTHER'S MAIDEN NAME: Katherine Lane Lynch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT: Mrs Morden Rigg

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocarditis Chronic — Interval between onset and death: 2 yrs

422.1 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

93d (b) Arterio Sclerosis generalized — Unknown

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb, 1947, to May 25, 1949, that I last saw the deceased alive on May 24, 1949, and that death occurred at 5:47 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Geo L Bond M.D. Annapolis Md 5-25-49

23. ~~BURIAL~~, CREMATION, ~~REMOVAL~~ (Specify) | DATE 5-26-49 | NAME OF CEMETERY OR CREMATORY Ft Lincoln | LOCATION (City, town, or county) (State) Prince Geo Co Md

DATE REC'D BY LOCAL REG. May 24, 1949 | REGISTRAR'S SIGNATURE W. O. Branch | 24. FUNERAL DIRECTOR John M. Taylor Son | ADDRESS Annapolis Md.

RECEIVED
MAY 28 1949
BUREAU V. S.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04452

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) Maryland Hotel

3. NAME OF DECEASED (Type or Print) (First) ~~Lillie~~ (Middle) Lily Crowley (Last) Wright

4. DATE OF DEATH (Month) May (Day) 10 (Year) 1949

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) W
8. DATE OF BIRTH Aug. 14, 1866
9. AGE last birthday 82 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Crowley
14. MOTHER'S MAIDEN NAME Elizabeth Briggs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Elizabeth W. Foster, Norfolk Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
420.1	Immediate cause	(a) Coronary occlusion	10 min.
94a	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	?
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cholelithiasis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 15, 1949, to May 10, 1949, that I last saw the deceased alive on May 10, 1949, and that death occurred at 7 25 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
E. Peyton Ritchings, M.D. 5/10/49

23. ~~BURIAL, CREMATION~~ REMOVAL (Specify)
DATE 5-12-49
NAME OF CEMETERY OR CREMATORY Elmwood
LOCATION (City, town, or county) Norfolk (State) Va.

DATE REC'D BY LOCAL REG. May 11, 1949
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR John M. Taylor & Son ADDRESS Annapolis, Md

RECEIVED
MAY 12 1949
BUREAU V. S.

04453

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 25

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn Park | LENGTH OF STAY (in this place) 4 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 104 Fifth Ave.,

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn Park
STREET ADDRESS (If rural, give location) 104 Fifth Ave.,

3. NAME OF DECEASED (Type or Print): (First) EDWARD (Middle) M. (Last) ZILE
4. DATE OF DEATH: (Month) May (Day) 9, (Year) 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months. Days	If under 24 hrs.: Hours Min.
Male	White	Married	12-29-1866	82 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Augustus Zile
14. MOTHER'S MAIDEN NAME: ,Mary Jenkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If year, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs. Grace Ruppel

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary heart disease

420.1 Antecedent cause(s)

9 da Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cerebral sclerosis

(c) Hypertension

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1942, to May, 1949, that I last saw the deceased alive on May 8, 1949, and that death occurred at 8 1/2 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Samuel Rubin M.D. ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify): BURIAL | DATE 5-11-1949 | NAME OF CEMETERY OR ~~CREMATORY~~ Ebenezer | LOCATION (City, town, or county) (State) Winfield, Carroll Co, Md.

DATE REC'D BY LOCAL REG. 5-9-1949 | REGISTRAR'S SIGNATURE Ida M. Whitaker

24. FUNERAL DIRECTOR C. M. Waltz, Winfield, ADDRESS Md.

May 11, 1949.

RECEIVED
MAY 13 1949
BUREAU U. S.